

FEDERAL BUREAU OF INVESTIGATION
 FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS OCT 11 1960

-60-035364

STATE FILE NUMBER

Registration District No. 171 Primary Registration District No. 5637 Registrar's No. 31

RECEIVED

1. PLACE OF DEATH a. COUNTY <u>Lafayette</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE <u>Missouri</u> COUNTY <u>Lafayette</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Wellington (rural)</u>		Length of stay in 1b <u>55 Yr.</u>		c. CITY OR TOWN <u>Wellington (rural)</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTE <u>St. Mary's 5 Mi. S.E. of Wellington</u>				Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>5 Mi. S.E. of Wellington</u>	
3. NAME OF DECEASED (Type or print) First <u>MARGARET</u> Middle <u>ANN</u> Last <u>FALLMAN</u>				4. DATE OF DEATH Month <u>September</u> Day <u>6</u> Year <u>1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. AGE (last birthday) <u>September 16, 1876</u> <u>83</u>	
				9. IF UNDER 1 YEAR Months Days Hours Min.		10. IF UNDER 24 HR	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Orrick, Mo.</u>	
12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>							
13a. FATHER'S NAME <u>Alexander Vanderpool</u>			13b. MOTHER'S MAIDEN NAME <u>Jane Campbell</u>			14. NAME OF HUSBAND OR WIFE <u>Edward Fallman (decd)</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Norman Fallman Wellington, Mo</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)			
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u>1953</u> to <u>9/6/60</u> and last saw her alive on <u>9-5-60</u> Death occurred at <u>8:30 A.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Joe W Ward M.D.</u>				22b. ADDRESS <u>Lexington, Mo</u>			22c. DATE SIGNED <u>9-10-60</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>9/8/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Machpelah Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Lexington, Mo</u>		
24. FUNERAL DIRECTOR ADDRESS <u>Vaughn-Walker Lexington, Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>10/7/60</u>		26. REGISTRAR'S SIGNATURE <u>Emma Davidson</u>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

Harold L. Walker

Licensed Embalmer No. 4588

P. O. Address Lexington,

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.